REVIEWING THE RECOMMENDATIONS OF THE PRESIDENT'S COMMISSION ON HEART DISEASE, CANCER AND STROKE*

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SOME years ago Sir James C. Spence[1] described three forces by which control of society and medicine had been gained and that must be constantly mobilized. These are universities coupled with research foundations, the medical profession itself, and the government. On this occasion we are concerned with the government's role. I thought it might be worthwhile—particularly in light of the recent critique by the American Medical Association of our Commission's recommendations,[2] which seemed to be based on a misunderstanding of them—for me to review the specific recommendations of the President's Commission on Heart Disease, Cancer and Stroke,[3] discuss the basis for them, and perhaps clarify some points.

The recommendations of the Commission were based upon certain principles, which we indicated in the report. We said specifically that the federal government shares in the responsibility for assuring that persons suffering from heart disease, cancer, and stroke have ready access to the benefits of the best in medical service, based upon the products of scientific research. Second, the federal government has a major responsibility for strengthening and broadening the support of research, which will generate new knowledge essential to the control of heart disease, cancer, and stroke. (I am talking about heart disease, cancer, and stroke because they were the Commission's concern. The Commission was established because these diseases account for about 71 per cent of the deaths in the country and cause a total annual loss of income to the country of about $35 billion.) Third, the federal govern-

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ment has a major responsibility for direct and diversified support of medical education and other programs designed to produce the health manpower upon which the control of heart disease, cancer, and stroke depends. These principles are basic; they may be applied, of course, to other diseases or health disturbances.

The recommendations of the Commission were made public in December 1964; there are 35 in all, which could be classified under five broad headings. The first group of recommendations provides the national network for patient care, research, and teaching. This has the most innovative thrust of all the recommendations. The next group of recommendations underlies and provides the means by which the network would be accomplished. These recommendations were designed to bring together the best in medical service and the best in medical research—region by region across the country.

The second group of recommendations, to repeat, was designed to contribute to the upgrading of the medical services and to support and strengthen the concept of the network. The proposed national network is based upon the concept that the best patient care is associated with research. It is not envisioned as a totally new and separate pattern of medical service superimposed from above. I should like to emphasize that point. Rather, the network is designed to become a part of the existing fabric of medical service; the existing universities, community hospitals, and research institutes will be the focal points for the centers and stations proposed. In some areas, through the development of medical complexes, individual regional centers and stations will be related to and integrated with existing health resources. The system is designed not to duplicate existing resources but to strengthen them. The purpose of the entire system is to assist the doctor in practice in the care of those of his patients suffering from heart disease, cancer, or stroke, and to make available to every doctor in the country the newest and most effective diagnostic methods and the most promising methods of treatment. It would, in our opinion, link every private doctor in every community hospital to a national, indeed worldwide network, transmitting the newest and best in health services. At the same time each doctor would contribute to research in these areas, for his observations will add to the total knowledge accumulated by stations, centers, and research institutes.

How the Centers Would Work

More specifically, we recommend the establishment of 25 centers for heart disease, 20 for cancer, and 15 for stroke, over a five-year period.

Each of the proposed regional centers for heart disease, cancer, and stroke would provide a stable organizational framework for clinical and laboratory investigation, teaching, and patient care related to the disease under study. It would be staffed by specialists from all clinical disciplines and the sciences basic to medicine necessary for a comprehensive attack on problems associated with that disease. These specialists would have at their disposal all necessary diagnostic, treatment, and research equipment and resources. The center would provide bed support for the patients under investigation as part of total care.

The centers would be strongly oriented toward clinical investigation and fundamental research. They would conduct training programs for personnel and staffing for diagnostic and treatment stations, and would also serve as a teaching function for the medical community of the region. The staff of each center must be large and varied enough to facilitate investigation and treatment in depth, utilizing multiple scientific methods. A regional heart center might, for example, include internists, cardiopulmonary physiologists, cardiologists, cardiac and vascular surgeons, biochemists, statisticians, epidemiologists, radiologists and, in some cases, geneticists.

In summary, each regional heart, cancer, or stroke center would be established, where possible, in conjunction with a major existing medical institution. It would be staffed and equipped to conduct advanced and complex clinical investigation and related research, plus teaching service and high-quality patient care. It would function as a regional resource for these services, interacting with the local diagnostic and treatment stations and with other medical resources in the area. A logical, organized program of research, teaching, and patient care in a regional center can vitalize the interests in the care of the patient, make available the latest techniques and resources in modern therapy, and discover new ones by application. By demonstration and professional education, the patients of the whole area may be benefited.

The recommendations for the network include the establishment of diagnostic and treatment stations in communities across the nation. The

staffing and operating costs in these stations should be borne in part by the federal government and in part by local resources. We on the Commission envisioned that such stations might even become self-supporting within 10 to 15 years. Emphasis was placed on local resources for the provision of care for medically indigent patients in the diagnostic and treatment unit. Patients other than the medically indigent would pay for their services. In that sense we were not trying to alter the pattern or fabric of local medical care.

The typical heart station, for example, would have the aim of providing: 1) immediate and emergency care for patients with acute cardiovascular emergencies; 2) diagnostic facilities for the screening of patients with cardiovascular, including peripheral-vascular, diseases, to determine whether they will require the most highly technical facilities which would be available at the larger medical center; 3) outpatient services for patients with cardiovascular and peripheral-vascular diseases; 4) stimulation of interest among medical students and practitioners; 5) training of physicians in the community; and 6) education of the general public concerning the prevention and treatment of heart disease.

Another set of recommendations again, in a sense, defines the role of the federal government in the application of medical knowledge in the community. Many individuals, agencies, and groups contribute to the health services received by heart disease, cancer, and stroke patients in communities of the United States. State and local health departments, in addition to their traditional and better-known responsibilities for the control of communicable disease, conduct active programs to serve the chronically ill as well. Voluntary agencies such as the local affiliates in the American Cancer Society and the American Heart Association assist in many ways. There are also the professional organizations: local medical societies and the various groups providing specific kinds of care, such as Visiting Nurse Associations. Each has a special part to play in the provision of health service. Manpower and facilities for the delivery of top-quality health care are in short supply in virtually every community. Therefore the efficient use of existing resources is imperative. Yet in many communities the reverse is actually the case. Instead of coordination, there is duplication of services and facilities in some areas, while serious gaps exist in others. The national network proposed would do much to strengthen and coordinate com-

munity services for these diseases; but more needs to be done if the full-scale attack on these diseases is to be fully effective.

The Commission devised recommendations to meet this challenge. The recommendations were designed to assure success by stimulating and supporting community programs and by encouraging the communication of health knowledge to the practicing physician and to the public. Note that the implication of these recommendations is a far cry from one of the statements made in the critique by the A.M.A. that ours was a centrally planned approach.

Another set of recommendations was made for the development of new knowledge; and here again the federal government has a role to play in the support of research and training activities in order to provide new knowledge in these areas. This is not in any way an innovation; we have now had long experience with the support of research in this area and the benefits that derive from it. The Commission's recommendations in this area for the development of new knowledge were designed simply to add further impetus to the powerful thrust of biomedical research that has taken place in recent decades.

The final over-all set of recommendations deals with the need for increasing health manpower. There can be no question of this. It has become increasingly evident: in fact, urgent. This set of recommendations was designed to provide support for this very important purpose. We also made a set of recommendations that I shall not discuss here.

I think, in summary, that the amounts of funds required to fulfill the Commission's recommendations are quite conservative. I think, too, that time will show that our recommendations in this area did themselves prove to be conservative.

REFERENCES

1. Spence, Sir James C. Disease and its local setting. In: Galdston, I., ed. *Society and Medicine* (N.Y. Acad. Med. Lectures to the Laity No. 17). New York, Intl. Univs. Press, 1955, pp. 3-19.
2. AMA Staff Report. A national program to conquer heart disease, cancer, and stroke, *J.A.M.A. 192*:299-301, 1965.
3. The President's Commission on Heart Disease, Cancer and Stroke. *Report to the President. A National Program to Conquer Heart Disease, Cancer and Stroke.* Washington, D.C., U.S. Govt. Printing Off., 1964.